Peer Support Providers

What is it?

A Peer Support Provider (PSP) is a person with a diagnosis of mental illness who has been trained to work with other persons living with mental illness. The training is comprehensive and significant, but the most important qualification for a PSP is the experience of living with mental illness. This training is designed to help you transform that experience into a uniquely individual service that only you can offer.

What does a PSP do?

A Peer Support Provider is qualified to help others in many capacities.

- They might offer services in an inpatient setting, an outpatient facility, or in someone's home.
- A PSP might work with other behavioral health service providers, probation officers, physicians, social workers, or teachers.
- They could teach others; support others in learning skills that help them reclaim their lives; advocate for others; or simply be available to listen.
- Sometimes a PSP will work closely with a team of professionals.
- Or a PSP might work independently with loose supervision.
- The Peer Support Provider helps others with mental illness discover their own strength and resilience, supporting them in getting what they want and need and in developing autonomy and independence.

The exact job duties of a Peer Support Provider will be determined by each employer, depending on need, but the role is consistent no matter what the setting.

A PSP is like a friend . . . but not a friend. A friend is someone whose trust we earn, a relationship that we work for. A PSP can *help* someone make friends of their own, and can fill that need for companionship while the person develops supports that will last over time.

What don't they do?

Peer Support Providers are not qualified:

- to offer medical advice or advice about medications
- to make diagnoses
- to tell people what they should do
- A PSP is not a junior case management provider, a lay counselor, or a substitute for a doctor

The role of PSP is not like anything you have seen before. Think about the role of the doctor, nurse, case management provider, and counselor. Each of those members of a service team has a specific role to play in offering services to people living with mental illness. Each of those roles was learned through training and education. The PSP also learns the role through training, but the most significant piece of education is the lived experience of mental illness and recovery. Nobody else on the team provides that experience.

Before we look at the role of the Peer Support Provider, consider the roles of the other members of the service team. Think about what you received from each of those people. What else would have helped you in your recovery? What service would you have liked to receive? _____

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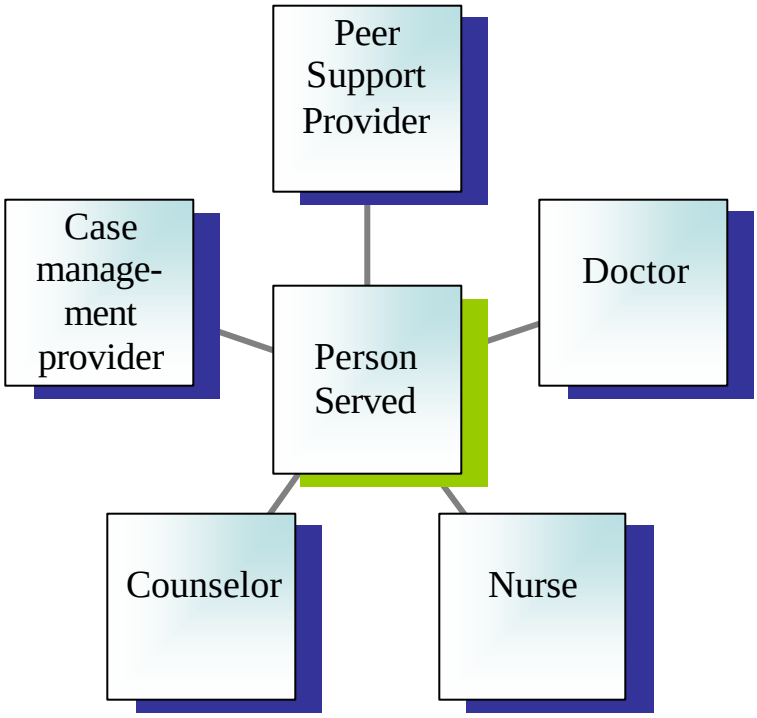

PSP Role

Consider what each member of the service team offers. The doctor prescribes medication and manages the medical aspects of care. The nurse helps with medication management and also keeps an eye on other medical conditions that might coexist with mental illness, offering medical education. The counselor uses specific theoretical frameworks and techniques to help people sort through challenges and develop tools. The case management provider helps people access services, avoiding duplication of services and tracking down the best possible solutions for each individual. What's left?

Before we answer that question, let's look at recovery. Peer Support Providers play an essential role in helping people move into recovery from mental illness. But what does recovery mean? It can mean many things to many different people. What does it mean to you? _____

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Recovery is something that we all experience in one way or another. We have all recovered from something: a broken leg, a bad case of the flu, an ended relationship. What kinds of things helped you recover from those experiences? Hint: don't get stuck thinking about "cure," because recovery is much more complex. _____

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Chances are, when you thought about what helped you recover, medication and counseling were not the most important elements of that recovery. For example, recovery from the loss of a loved one is very similar to recovery from mental illness. When the loved one dies, at first it is the only thing you think about. It consumes every waking moment, and you may feel as though nothing will ever be the same again. Sometimes it is so painful, we have trouble believing we will ever smile or laugh again. Over time, though, you think about the loss a little less. One day you wake up and realize it was not the first thing you thought about. Slowly, your life regains a shape and structure; you move on. In fact, you "recover" from this loss. Recovery in this sense does not mean that the loss never happened. That is a fact that cannot be changed. But knowing that it happened, you made sense of your life and rearranged it around that loss, making new meaning for yourself and moving ahead with your life. Many people say that recovery from mental illness is like this: they make new meaning based on the experience of mental illness, reshape their lives, and go on with living.

If you have had an experience like this, what helped you recover? Was it something like what you mentioned before when thinking about recovery? _____

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Many people, in the list of things that helped them recover, list "friends" or "family" or "relationships." The support and encouragement of others is often crucial to recovery of any kind. Sometimes that support means the person did something specific for you, like run errands you could not manage, or bring food when you had no energy to cook for yourself. Sometimes that support means the person sat with you, not even saying anything. Have you had an experience in which someone was able to just "be" with you? That person probably did not have to say something wonderful, or offer solutions, or fix anything for you. They just sat with you in your feelings. It is a very powerful experience.

If you have had this experience, or if this explanation makes sense to you, you are starting to understand what a Peer Support Provider does. Here are some more specifics.

PSP Does	***PSP Doesn't***
Focus on the person's strengths	Dwell on problems or limitations
Listen to people's experience	Interpret what their experience means
Teach people to be independent, autonomous	Make people dependent upon us
Show that people can get better	Define what "getting better" is for others
Accept people just as they are	Try to make people behave to our standards
Sit with people when they need support	Offer solutions or "fixes"
Encourage people to succeed	Define success for others

Unique Role of Peers

Human services, as a field, is based upon relationship. Trained professionals have lots of tools to help people recover, but the real magic occurs in the connection between two human beings. As a Peer Support Provider, relationship is the single most important tool in your toolkit. The quality of your relationship with the people you serve will be somewhat different than the relationships developed by other providers, based on your different role.

As people living with a mental illness, when we have worked with a doctor or other professional who provided services for us, we probably looked to them as the experts. Their education and license may have led us to believe that they knew more about what was happening with us than we did. It is certainly true that they have knowledge and expertise that most of us do not share. Yet we are the ones experiencing the illness. We know what our symptoms feel like; we know the pattern of our symptoms; we know what helps us and what does not help. We can make decisions about treatment, including medications. We know what we want and need.

Because the person living with the illness has important knowledge about his or her experience of that illness, we encourage people to become full partners in the treatment of their illness. All the members of the service team have knowledge about aspects of illness that can help people recover. All of these things are tools, and each individual can decide which tools are most effective. The PSP encourages and supports people in learning about the tools that work best for them. Instead of recommending or advising people, the PSP provides support and encouragement for each person to discover their own strengths and capabilities. This relationship is a partnership in the truest sense of the word.

We will look again at the role of the Peer Support Provider when we talk about helping people recover from mental illness. One of your tasks will be to help people discover and mobilize their own strengths. Other members of the service team may also have this focus, and you can support them in this goal.

Many of the things you learn in this training will seem familiar. As people who have received mental health services, we know how the professionals behave with us. Most of us can copy that, right down to the language and the boundaries. But those roles are different than the role of the Peer Support Provider. Each role on the service team has its own skills, its own goals, its own ethical and boundary guidelines, and its own philosophy. Everything you learn in PSP training will have a slightly different "slant" based on the different role.

What Will I Do?

Here are some examples of the kind of work that Peer Support Providers might do. Keep in mind that your actual job description will depend upon the agency that hires you.

- Visiting people in their homes
- Helping people access resources in the community
- Teaching people how to use public transportation
- Working in psychiatric inpatient settings
- Developing relationships of trust with others
- Helping to engage people who are hard to reach
- Performing outreach to people who need services and to other service providers
- Partnering with other service providers to offer the very best services

Recovery From Mental Illness

Can you remember the first time you heard that you could recover from mental illness? Was it a long time after you were diagnosed? Imagine how it would be if, the first time we heard that we had a diagnosis of mental illness, we also heard—that same moment—that we could recover. How would it change the course of our illness and the pattern of our recovery? _____

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Almost 200 years ago, in the early 1800s, a treatment for mental illness called Moral Therapy

was pioneered. In this treatment, people experiencing psychiatric symptoms were taken to a clean, quiet place where they were treated kindly, given healthy food, allowed long walks in the quiet countryside, and allowed to rest and recuperate until they felt better. Around 1835, some studies were done on this program. The studies showed that between 52% and 58% of people undergoing Moral Therapy recovered (P. Deegan, Ph.D., 2002). This was very exciting news, and Moral Therapy became very popular.

Once Moral Therapy became well-known, families began to send their loved ones to these programs in huge numbers. As it turned out, Moral Therapy worked very well in facilities that were spacious, clean, well-staffed, and uncrowded. With huge numbers of people coming into these facilities, they became crowded, chaotic, noisy, and understaffed. In these conditions, the program could no longer be considered Moral Therapy. Staff had all they could do just to manage people and keep them safe and fed. Some people thought this "proved" that Moral Therapy did not work. In addition, the percentage of people who recovered was looked at from a different perspective: at this time (around 1880), they thought "only" 52-58% of people

recovered. Over time, with overcrowding and understaffing, this turned into the common belief that “people with mental illness do not recover.”

By the middle of the 20th Century, psychiatric medications became available to help ease some of the symptoms of mental illness. The earliest medications had many uncomfortable side effects. Newer medications often are more effective, with fewer side effects. But medication was not a cure, and most people with mental illness were still told that they would continue to experience psychiatric symptoms for the rest of their life. Many were told to go on disability and lower their expectations. This prediction doomed many people to a life of poverty, without purpose, education, career, often without friends or family. When we believe that there is no hope for us to recover, it is hard to keep struggling to feel better.

In the last half of the 20th Century, researchers around the world began to study people with mental illness, once again. They learned some interesting things.

- As many as half of all people with mental illness recover, *whether or not* they get any treatment or professional help
- Nearly 70% of all people with mental illness recover, given some form of treatment or professional help
- People may have setbacks but can still be recovering
- Medication is only one of many tools to help people recover
- There are no predictors about who can recover
- Type of diagnosis made no difference in the statistics; people can recover, no matter what their diagnosis or symptoms

The studies considered most important were done by Courtenay Harding, Ph.D.

Let's be specific about this word "recovery." Every person who is recovering from mental illness can define "recovery" in a way that has meaning for him or her. The researchers, however, had to use some standard definitions. For the purposes of the studies done over the last 50 years or so, people were considered to have recovered if they had four or five of the following six criteria:

1. No current signs or symptoms of mental illness
2. Living independently in the community
3. Stable source of income
4. Enduring, supportive human relationships
5. No current medication
6. Appearance such that nobody would know, by looking at you, that you had been in the hospital

Note that people did not have to meet *all* these criteria to be considered recovered. In other words, we may continue to take medication for the rest of our lives, and we may occasionally experience a symptom of mental illness, but we can still recover. We can recover especially in the sense that we reclaim our lives, our dreams, and our relationships.

What definition would you use to describe a state of recovery for yourself? _____

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When you are providing services, how will you explain recovery to someone else? _____

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Once we understand recovery, it is easier to understand the role of the Peer Support Provider. We know that medical personnel provide the medication that supports us by relieving or minimizing symptoms. Counselors help us work through challenges, and case management providers help us access services. Peer Support Providers offer support, guidance, encouragement, and some landmarks along the way to recovery. We model hope for recovery. We share our experience to give others some ideas about how they can move into recovery. But because recovery is so personal and unique to each individual, we take care not to define recovery, or to insist that there is only one way to recover. We know that some common psychiatric medications do not work well for everyone (sometimes related to metabolic differences among ethnic groups). Similarly, no two people will recover in exactly the same way.

Do you consider yourself to be recovered, or recovering? _____

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What does that mean to you? _____

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In what ways would you like to continue or expand your recovery? _____

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What can you do to help others find their own recovery? _____

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One of the most important ways in which the PSP helps people to recover is to keep the focus on a person's strengths, rather than dwelling on the problems. It's not our job to keep track of or give advice about medications or medical conditions. The person receiving services may choose to talk to us about their symptoms, and we may be able to help them find tools *in addition to* medication that can help them with symptom management. Often this conversation will include asking them about their strengths, their experience, things they already know. Here are some examples of how focusing on strengths differs from focusing on problems.

Problem Focus	*Strengths Focus*
People are viewed as "at risk"	People are seen as having many strengths
The person is defined as "the problem"	The person is recognized as a unique individual, in spite of problems
Language focuses on the problem, and the person as a "victim" of the problem	Language keeps possibilities and strengths in the forefront
We ask people to help name the problem or deficiency	We ask people to help us discover who they are
Experts know the person from the outside in	We know the person from the inside out
Experts doubt the person's stories; those are "excuses" or "rationalizations"	The person's stories or narratives are sought out and believed
Experts set goals, and the treatment plan is the focus of the work together	The individual sets goals, and his own aspirations and dreams are the focus
Professionals are the experts	Persons receiving services are the experts in their own lives
The expert develops the treatment plan	Work together is collaborative, but driven by the goals of the person receiving services

Possibilities are limited by the person's diagnosis, limitations, etc.	Possibilities are always open, guided by strengths
Resources for work together are the knowledge and skills of the professionals	Resources for work are the strengths and capacities of the person receiving services, and community supports
Help focuses on solving problems, controlling symptoms, etc.	Help focuses on getting on with life, returning to full membership in the community

Adapted from Compton and Gallaway, 1999.

What Are Strengths?

Every person has strengths, just like every person has challenges. In this sense, people with mental illness are no different than any other person. We have challenges (in our case, our psychiatric symptoms) and we have strengths. As people with a mental illness, we may come to believe that our challenges outweigh our strengths. This is especially true if we have been receiving services for a long time, and have been told that we will always be ill and on disability. It's crucial to recovery that we learn to recognize our strengths and to bring them into play in our lives again. Strengths can come from a number of sources:

- *Culture and traditions*: these familiar stories and patterns may be a source of connectedness, guidance, and comfort.
- *Innate talents and gifts*: skills that we have learned at work, at home, anywhere, that can be used in the community to strengthen friendship and reduce the sense of uselessness.
- *Hopes and dreams*: an important guide to goals, and a source of energy.
- *Spirituality or religion*: for many people, the source of meaning that keeps them going through hard times.
- *Personal characteristics*: such as loyalty, insight, sense of humor, kindness, patience, determination.
- *Acquired knowledge*: the things we've learned in life so far.
- *Life lessons*: especially what we've learned about ourselves and others as a result of having a mental illness and experiencing the struggles associated with that.
- *The community*: Every community has resources that can add to the strengths of the individual, supporting and providing connections and meaning.

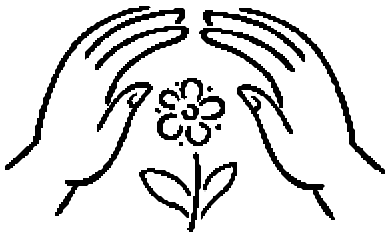
How Do We Discover Strengths?

Ask! Always ask the person before trying to guess for yourself. Allowing people to uncover their own strengths will add to their sense of mastery. When we ask questions that lead people to feel better about themselves, we let them know we're interested in them as unique human beings. Ask questions like:

- How did you get this far? What helped you survive this? What did you learn?
- Who helped you? What did they do that was helpful? Why did they help you?
- What good things do people say about you? What things about yourself or your life give you the most happiness? What are your best memories?
- Where do you want your life to go? If you could rewrite your life story, starting today, how would the story change?

Other clues to a person's strengths may be found in their surroundings. If you are in a person's home, look around. Do you see evidence of particular skills, gifts, or interests? Ask questions about the hints you see.

Listen to the stories told by people receiving services. Encourage people to tell stories in a way that shows their survival skills. This slant on our own story can often uncover strengths we didn't recognize previously. Telling our stories in this way helps us transform the story of our life from a sad, painful burden that we would like to forget, into an example of courage and triumph.



A few words about words . . .

People living with mental illness often learn to identify themselves with their diagnosis, saying, for instance, "My name is _____ and I'm bipolar (or manic depressive, or schizophrenic, etc.)." It's a habit we may have picked up from hearing our label over and over again, or from being in settings in which the diagnosis is our most prominent feature. People with physical disabilities have something to teach us about this. It's become common practice when referring to people with physical disabilities to use "person first language." For instance, instead of calling someone a paraplegic, we refer to a person with paralysis. Instead of saying someone is an epileptic; they can be called a person with epilepsy. Similarly, we avoid calling people with mental illness by their diagnosis. We could say that someone is a person with a diagnosis of _____, or a person living with mental illness.

What difference does it make? It's easy—and quick—to refer to someone by their most obvious characteristic, which may also be their biggest challenge. When we do that, it's easy to forget that the person is much more than the sum of their challenges. Another problem with this language is that we forget that people are individuals. Each person who uses a wheelchair is different, with perhaps a different reason for their situation and a different way of coping with that challenge. Each person with a diagnosis of bipolar disorder is an individual, with a unique story, individual ways of coping with the challenge, and much more to the sum total of their being as a human. Finally, calling people by their labels can perpetuate stigma and negative images of people with mental illness. Yes, it takes a little longer, a few more words, to use "person first language," but that extra effort can remind us to look for the whole person within, the individual whose strengths are more important than their challenges.

More specific guidelines are available in the American Psychological Association Publication Manual (5th edition), or at the APA Online site. See the end of this section for references and further reading.

Further Reading and References

American Psychological Association (2001). *Publications Manual* (5th ed.). Washington, D.C. http://www.apastyle.org/disabilities.html

Compton, Beulah R. and Galaway, Burt (1999). *Social Work Processes* (6th ed.). Brooks/Cole Publishing Company.

Deegan, Patricia (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal, 19*, 91-97.

DeSisto, M.J.; Harding, C.M.; McCormick, R.B.; Ashikaga, T.; Gautam, S. (1995): The Maine-Vermont three decade studies of serious mental illness: I. Matched comparison of cross-sectional outcome. *British Journal of Psychiatry, 167*, 338-342.

Cultural Competence

Culture refers to the way people live, guided by the way we think and believe. Most people think about race or nationality when we think of culture, but culture can also reflect religious beliefs, sexual orientation, disability, hobbies and interests, education, talents and skills, occupation, and many other categories. For instance, when you work at a large company, that company has a specific culture that reflects its mission, its management style and work habits. People living with mental illness also have a culture, which is largely shaped by the way services are delivered in their area.

A person's culture is reflected and made known in many ways, some obvious and some very subtle. What kinds of things are a reflection of culture? _____

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Most people live in more than one culture, just as we live in more than one community. For instance, we may participate in a culture related to our nationality. The culture at our workplace may be different than our national culture. The neighborhood in which we live may reflect an even different culture. Our workplace, our neighborhood, and members of our nationality are also communities. Can you identify some of the cultures in which you participate? _____

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Peer Support Providers may be called upon to work with anyone, at any time. We do not get to choose who we will work with. Like any other behavioral health professional, we have a responsibility to be prepared to offer services to anyone in need. We are also responsible for being prepared to offer the best possible services, in a way that suits each individual best. In order to do that, it is important to understand some of the cultural variables that we may encounter. We also need to understand our own culture. Take the Cultural Identity Survey to get a picture of your personal culture.

Consider some of the elements of culture, and the ways in which they are reflected. Can you see some ways in which we might misunderstand each other? Some things that people do as a reflection of their culture could easily be misinterpreted as a psychiatric symptom.

For example, what would you think if someone refused to make eye contact with you? _____

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What would you think if someone would not shake hands with you? _____

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Would you think it odd or "symptomatic" if someone ate with their fingers? _____

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What would you think if a person was very quiet and spoke very little? _____

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All of these things might be the way someone behaves because it is considered polite in their culture. They are not the way most people in the U.S. act when they are feeling well, but that does not make them abnormal. Be careful not to assume that any unusual behavior is a psychiatric symptom.

Some aspects of our personal culture are very dear to us. In fact, they may be so dear to us that we have always considered them to be "the right way" to do things. Expressions of respect, child-raising methods, generational relationships, and religion in particular are often invested with a value judgment. We strongly believe that our own ways of doing things, or our own beliefs, are the "right" ones. This is a strength that helps many of us recover and find meaning in our lives.

We may find ourselves working with someone whose beliefs and behavior are very different than our own. What will you do when you find yourself working with someone whose beliefs conflict with your own? _____

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What will you do when the person you are serving treats her children very differently than you would? _____

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What will you do when someone habitually acts in a way that seems disrespectful to you? ___

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What will happen when the person you are serving makes a life choice that conflicts with the beliefs of your religion? _____

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It is tempting to think that we could discontinue providing services for someone when we find out that their beliefs conflict with our own. It would certainly be more comfortable for us if we could do that. Let's think about what happens to the person receiving services when we ask to be reassigned.

Imagine that you have been struggling with psychiatric symptoms for a long time. Maybe your family doesn't understand and they don't treat you every well. You have not been on a date in years because people think you're too strange or scary. You have not worked in a long time because the stress is too hard to manage. The neighbors look at you like you are dangerous when you pass by their house. Even the people on the bus won't talk to you. One day, a Peer Support Provider is sent to help you recover. This person is just like you, living with mental illness, but farther along in recovery. Their generosity in sharing their experience makes you feel like you have some hope, you are not an awful person. The PSP may be the first person who has accepted you in a long time. Then you hear that the PSP has asked to stop working with you. How will you feel? Will it feel like nobody will ever like you, if even the PSP can't?

As a Peer Support Provider, we are in a uniquely important position. While we do not have actual power over the person receiving services, because we are peers, our opinion and acceptance carry enormous weight. Part of our mission includes the ability to share hope with people, to keep believing that they can get better, and to help them mobilize their unique strengths and skills to do just that. Culture and beliefs are among the most vital of the strengths and skills we possess. Our culture and beliefs can be a source of meaning and courage that support us in our recovery. As a PSP, we must do nothing to damage a person's connection with their strengths.

It is possible to hold deeply our own beliefs, and yet allow others to be strengthened by theirs, even when the beliefs are very different. What can you do to allow others to fully realize their strengths? _____

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How can you let others know that you believe differently, but that does not mean your beliefs are more important than theirs? _____

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Have you ever been to a football game? From your seats, you had one particular view of the field. Let's say that at this football game, you saw a player fumble the football, and a player on the opposite team grabbed it and fell on it. Everyone sitting around you saw the same thing. At this same game, you had a friend sitting in a different section. From their particular view of the field, they saw something different: the original player did not drop the ball, but it was knocked out of his hands by the opposing player. Everyone sitting near your friend saw this same thing. Now let's say you both have cell phones, and you call each other to talk about this play. You believe there was a fumble, and your friend believes there was instead a steal. Since you each have people sitting around you and supporting your beliefs, you each insist that you are right and the other one is wrong.

Of course, disagreeing about a play in a football game is not as important as disagreeing about one's beliefs. But you can use this same perspective. Each of you has a particular "view" of the universe and how it works. Each of you has a belief tied to that view, probably supported by others. Therefore you believe that your view is right. When you are disagreeing with somebody to whom you are providing services, try to remember that you are just sitting in different parts of the stadium.

Recovery Tools

Recovery is a process that is different for everyone. Each of us recovers in our own way, and each of us has certain "tools" that have helped us in particular. This module will introduce you to some of the best known recovery tools.

Most people think that medication is the major treatment for serious mental illness. It's true that medication is helpful for many people. It's also true that many medications have unpleasant or even intolerable side effects. What happens when the medications don't work? Aren't effective? Have side effects you would rather not experience? People have been experiencing mental illness for centuries. What did they do before medications were available?

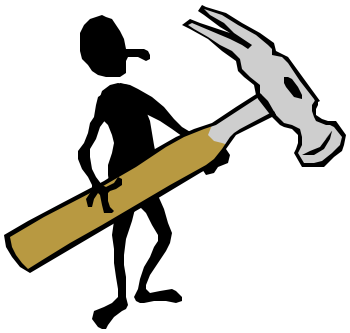
One of the best known recovery tools is the Wellness Recovery Action Plan (WRAP). WRAP was developed by Mary Ellen Copeland, MA, MS, in conjunction with many people who live with mental illness. The program is designed to help us monitor and manage our own symptoms. While WRAP is a specific format and structure, it is flexible enough to be adapted by anyone to meet their own specific needs.

WRAP consists of six parts: Daily Maintenance, Triggers, Early Warning Signs, When Things Are Breaking Down, Crisis Plan, and Post-Crisis Planning. Each of these parts begins by identifying what each is like for the individual. Then the person creates an action plan to help manage things that come up in this state. WRAP is flexible enough that it can be used for people with or without psychiatric symptoms to manage the stresses and demands of everyday life. It can be used to manage chronic illness, substance abuse difficulties, life changes, emotional distress, and a wide range of other conditions.

Medications work because they change our brain chemistry. There are many other ways in which we can change our brain chemistry, but the effect is less noticeable. These other methods include diet, exercise, sleep, relaxation, creativity, diversionary activities, support, and spirituality. We can experiment with these things to find combinations that support our optimal

health and wellness. WRAP provides a structure for employing these methods in a methodical way. Some people are able to lower the amount of medication they require; some people are able to discontinue medication altogether. WRAP is meant to help people take charge of their lives in a way that lets them control their mental, emotional and physical responses.

WRAP is published by Peachtree Press. You can access Mary Ellen Copeland's WRAP and her many other publications at her website: http://www.mentalhealthrecovery.com. Other books cover topics such as depression, bipolar disorder, recovery from trauma, winning over relapse, and fibromyalgia.



The Consumer Organization National Technical Assistance Center (CONTAC), in West Virginia, offers a Leadership Academy that is available throughout the country. This training is nationally recognized as an exemplary program. It is designed to help people with psychiatric disorders learn skills in organization and civic participation. CONTAC brings this training to groups of people upon request, as often as they can. To learn more about this training, contact Larry Belcher at the West Virginia Mental Health Consumers Association, (800) 598-8847, or larrybelcher@contac.org.

Ed Knight, Ph.D., and Ike Powell designed a recovery workbook titled, "Getting A Life: A Course of Action for People Diagnosed With a Serious Mental Illness." The workbook includes ten modules covering topics such as:

- ☆ Being the expert in one's own life
- ☆ Managing thoughts and emotions
- ☆ Creating a new life instead of trying to change the old one

- ☆ Being responsible for one's life and recovery
- ☆ Despair
- ☆ Negative thinking

"Getting A Life" is available from Ike Powell, Innovative Group Processes, 909 Forest Street NW, P.O. Box 209, Cairo, GA 31728. Trained instructors are available locally in Arizona.

What are some of the "tools" you have used to help you recover? _____

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How do you think you can help others discover tools that work for them? _____

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Using Strengths-Based Practices While Understanding the Signs and Symptoms of Serious Mental Illness

You have been learning about mental health recovery and strengths based practices since your first day of training. You will be working in many settings. You may find that you are the only person in a setting that knows recovery from the symptoms of mental illness is possible. You play a vital role in carrying the message of recovery to every setting, every meeting, and every person you are involved with. While you may have a clear understanding of recovery, others may not. They may work from a medical model that focuses on the illness and treating it. A recovery model works from a perspective that focuses on strengths. A strengths-based model never stops believing in the ability of people to persevere. People who do not know about strengths-based ideas can learn. They often lack hope, because they do not see that strengths exist. An important part of your work is being a role model. You are the example.

The DSM-IV-TR as a Tool for Diagnosing Mental Illness

The DSM-IV-TR is the tool that is used by many providers of mental health care. Psychiatrists, nurses, social workers, counselors, psychologists, case management providers, and a host of others, who work with us, use this tool to identify a particular set of behaviors that are consistent with one of the labels in the DSM. This manual was created as a means of billing, and as a means of developing a common language for behavioral health providers to use.

Do you have a label? Perhaps you have more than one. Do you identify yourself by saying your name and your illness when you are with people who are in a position of power over you? Think about some reasons you might do this. What are they?

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It is important to know some of the diagnostic labels you might hear in your work, however, in strengths-based practice, labels do not define the human being that is behind the label. We will discuss the various labels here so that you are familiar with them and can understand the people

you are working with when they use them. However, it is vital that you remember as Peer Support Providers, you do not know people as their labels. You are an advocate for giving names to the behaviors and feelings instead of giving them a label.

As you become confident in your role as a Peer Support Providers, you will be expected, by those who understand your job, to advocate for the use of descriptions and words that are not hurtful or stigmatizing. Whenever you hear things like, "She's just doing her borderline thing…" You must skillfully and tactfully reframe that language. As you gain knowledge about the behaviors that might characterize this label, develop methods that you can use to redirect the language to a more feeling and recovery oriented description. For example, you might reframe the statement above like this:

- "Susan is having strong feelings of loneliness because she is always by herself. Perhaps we can help her discover some new support systems."

The DSM gives numbers to each diagnosis. That is what insurance companies look for when reimbursing a bill. There are four main categories that encompass the symptoms usually related to Serious Mental Illness. They are:

- Schizophrenia and Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Personality Disorders

Mental illness is not considered Serious Mental Illness unless a person experiences a profound psychological or biological change and:

- ✓ It is not the result of a life event such as a loss of some kind
- ✓ The duration must be longer than six months if the behavior is the result of a significant life event
- ✓ The person's life must be severely impacted by these changes

For example, the changes may cause them to lose their job, or stop associating with other people, and they might sleep all day or be awake day and night. The person changes in significant ways that cause huge changes in their life.

Serious Mental Illness can be seen as having four components:

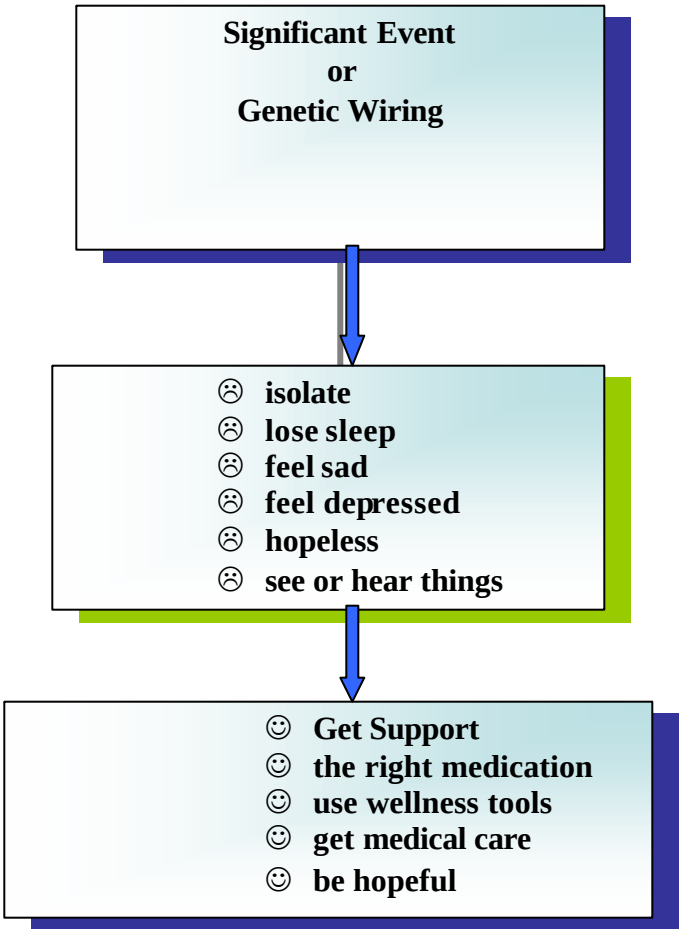
- Biological
- Psychological
- Sociological
- Spiritual

Biological

The biological component is the part of the illness that responds to medication. The person may have started out grieving the death of a loved one. Their grief persisted and as they grieved, their body stopped sending out endorphins, the body chemicals that occur naturally when we feel good and are happy, or excited, or we exercise. When the body stops sending endorphins, a void is created in that chemical in the body. Therefore, even on a good day, the person does not feel "good." Another possible thing that happens is a person might have a genetic predisposition to something such as depression. That person's body may be "wired" for depression. In both of these instances, medication can replace what was lost or can create a means for the "wiring" to work better. Neither of these people is inherently bad, or lacking intelligence…they have a chemical imbalance, and medication or other things (meditation, exercise, recreation etc.) can help them.

- medication is one way to treat symptoms
- exercise helps the body's system generate endorphins
- meditation or other relaxation exercises relieve stress
- medication can be used with other wellness tools that you find helpful, each person develops their own set of wellness tools (Copeland, 1998)
- getting outside in sunlight can help in some situations
- being with people we care about and who care about us can help

The Biological Component

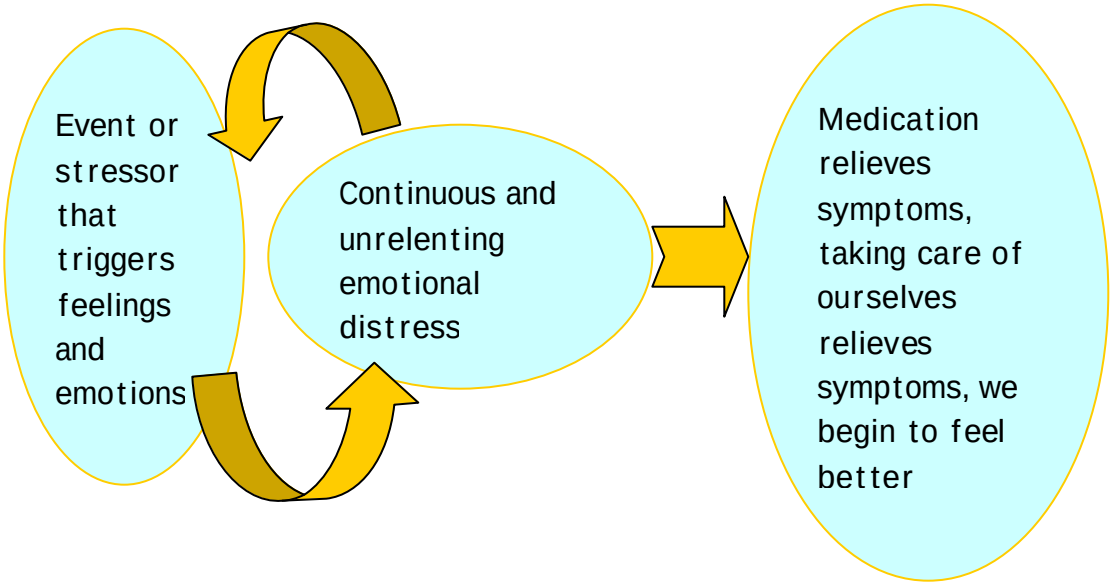


(Cop
eland, 1998)

Psychological Component

The psychological component is the part that occurs because of a life event, trauma, abuse, or something else that has occurred, which has affected the person's sense of self. People report sometimes that they are not who or what they used to be. Their life may have always been difficult. They may have lived under continuous unrelenting stress and this ate away at their self-esteem. Can the psychological lead to the biological? As explained above, it can. Sometimes it is a question like the chicken and egg question. Who knows which came first? It is not important. It is only important to know that people can and do get better.

Psychological Process



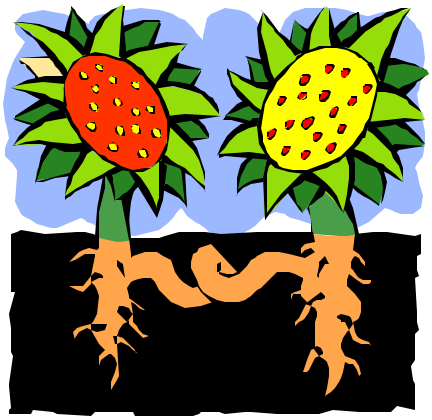
Sociological Component

The third component is a sociological component. When people begin to have uncomfortable symptoms, they may encounter events that have almost a domino affect. They may lose their job, which may lead to problems with money. They may have to rely on Social Security to try to survive. The low income from social security may cause them to live in dangerous neighborhoods. All of these things increase stress. Stress can increase symptoms. Sometimes it is more difficult to recover from the effects of mental illness than it is to recover from the symptoms (Anthony, 2000). Mental illness carries a significant stigma. What is a stigma? Here is a definition from The American Heritage Dictionary of the English Language (1765):

- A mark or token of infamy, disgrace, or reproach. Or, a mark or characteristic indicative of a history of disease or abnormality.

But…stigma also means:

- *The receptive apex of the pistil of a flower, on which pollen is deposited at pollination!*



Stigma can mean something negative, or we can see ourselves as being the stigma that allows flowers to grow and spread. We can take our experiences with mental illness and make them work for us. We can spread the idea that we can get better and are strong people with courage and determination like bees spread pollen among flowers.

This does not mean that stigma is not difficult to cope with, but as Peer Support Providers, you have the opportunity to diminish stigma. Your presence in any setting will begin to lessen stigma as the people you work with observe you as capable and helpful and as you guide the people you serve to the belief that they can get well.

Spiritual Component

The fourth component of mental illness affects spirituality. This is often experienced as a loss of the meaning of life. People often lose contact with the people or beliefs that gave them strength. The idea of a spiritual component of recovery has been around since Alcoholics Anonymous began in 1935. However, in mental health, this concept is a bit different. Rather than believing we are helpless to find our recovery, we believe that we can develop the skills and strengths to help us take personal responsibility for our recovery (Copeland, 1998). How can you help someone develop skills and strengths that will help them get better?

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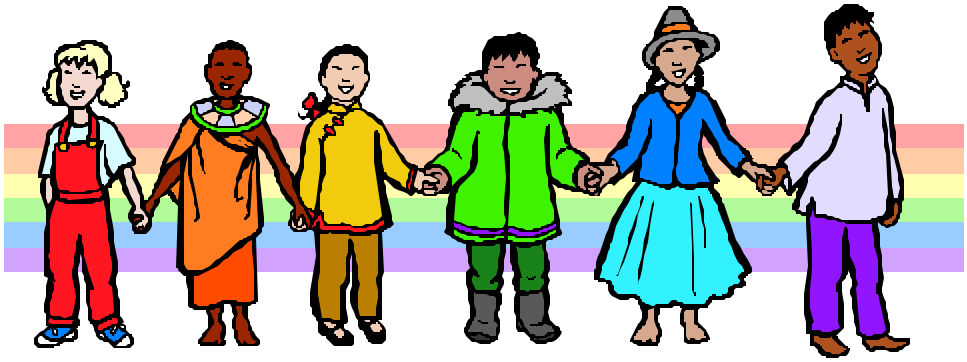
Helping people develop “roles” in life assists them in developing broader thinking about themselves in relation to the world. As a Peer Support Provider, you can help someone by allowing them to help you sometimes, allowing them to identify the many roles they have in life.

Maybe they have a role as a parent. You can help them begin to identify their role as a friend, as you deepen your relationship and help them connect with others (George H. Mead, as cited in Turner, 1996).

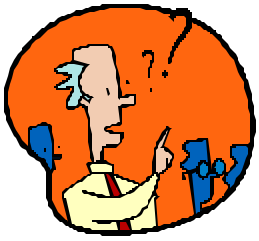
As patients, we often get stuck in that role. We forget that we do not always need someone to take care of us. We can remember that we can give help by being provided with opportunities to assist others. Just as your job as a Peer Support Provider will help you develop a role as an employee, a helper, a professional, and begin to increase your sense of well-being, the people you serve can discover those roles too. You can help them find more roles in life.

In addition, people may want to reconnect to their spiritual side; they may begin to feel connected to God or their spiritual core. They may find that being part of a community is important. That community may or may not be faith-based. However, it will help them begin to feel part of the world around them and rediscover who they are.



As we begin to learn about all the ways that mental illness affects our lives, do you see that some of the most important ways it affects us are more than a diagnosis? The behaviors or symptoms associated with our illness are the things that we must work with each day so we can get well and stay well. On any given day, any person might have symptoms that fall into some categories of the DSM-IV-TR. Does this mean that everyone has a mental illness? Really think about this before you answer.

Does anyone want to share their answer?



Diagnostic Categories

(the following lists and symptoms are taken from the DSM-IV-TR)

Now that we have explored some ideas about mental illness, we are going to stop back at the four diagnostic categories so that you will have a basic understanding about what symptoms are identified as corresponding with each broad category. Remember, in a strengths-based system, we are concerned with helping people remember how strong they are and how well they cope every day. We are not concerned with labels and looking for behaviors that validate the label that they have been given.

Schizophrenia and Other Psychotic Disorders

Here is a list of behaviors that are associated with these diagnostic labels:

- People may think they are someone they are not (delusions)
- People may hear, see, smell or feel things that are not there (hallucinations)
- People may have disorganized speech
- People may not move (catatonic)
- People may experience very disorganized behavior
- People may experience significant fear of others or the world around them

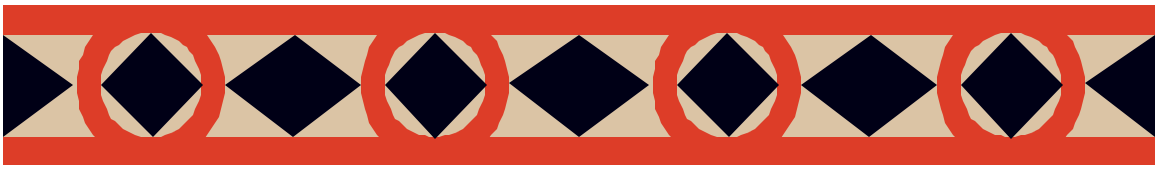
- The above behaviors are sometimes called *positive symptoms* in that they are observable or actively occurring.
  - People may not be able to communicate
  - People may not talk
  - People may stop eating
  - People may stop having facial expression or expression in their voice (this is called *flat affect*)
- The above behaviors are sometimes called *negative symptoms* in that they involve a loss of something that is present when the person is not having symptoms.

Please take a moment to notice that the word **person** was used each time a description was given. This was done to remind us that a person exists within this set of symptoms. Often, in the fast-paced settings of mental health care, the symptoms are described with little reference to the person experiencing them. As we work, we must be ever mindful of the person behind the set of symptoms being described.

Mood Disorders

Depression

- The person experiences a depressed mood most of the day nearly every day
- The person experiences anhedonia (a lack of ability to feel pleasure)
- The person may experience a significant weight loss or weight gain
- The person is unable to sleep or sleeps most of the time
- The person feels slowed down or speeded up
- The person feels tired or fatigued nearly every day
- The person may feel excessive guilt
- The person may feel worthless
- The person may experience confusion or what is spoken of as an inability to concentrate
- The person may be unable to make decision
- The person may have recurrent thoughts of death or fear of death
- The person may think about suicide frequently with no plan
- The person may think about suicide and have a plan or attempt to commit suicide



Manic (occurs with bi-polar disorder)

- The person may have feelings of being more than wonderful
- The person may have a decreased need for sleep
- The person may talk without stopping and may feel a need to keep talking

- The person may have trouble keeping track of thoughts, thoughts may occur one right after another and feel like they are racing
- The person may experience difficulty concentrating
- The person may experience a high energy level and a need to begin tasks
- The person may engage in pleasurable activities that may also carry high risk, that may cause them problems later, like excessive spending
- The person may be grumpy or easily angered

Anxiety Disorder

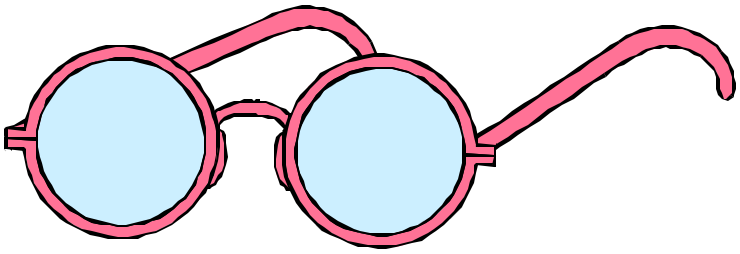
The next grouping of symptoms has to do with anxiety. Many of us can describe feelings of uneasiness and we know that anxiety is present in many people. Some people may have a high level of anxiety a lot of the time. Anxiety becomes difficult for people when it begins to prevent them from engaging in their usual activities in life. There are several types of anxiety that can become overwhelming. They are:

Panic

- The person might feel their heart is pounding
- The person might feel they are trembling, shaking
- The person might be sweating
- The person might feel shortness of breath or as if they are smothering
- The person might have a feeling of choking
- The person might experience chest pain or discomfort
- The person may experience nausea or abdominal distress
- The person might have a feeling of dizziness, lightheadedness, or as if they might faint

- The person might have feelings of derealization (feelings of things not being real), muffled sound, being detached from oneself
- The person might fear losing control or going crazy
- The person might express that they feel as if they are dying
- The person may experience numbness or tingling sensations especially in hands and feet
- The person may have chills or hot flashes

The ways that a person feels when they are experiencing panic can be the same way they feel when they are experiencing other types of anxiety. So, you can refer to the above list for many other types of anxiety. Remember, people can learn to help themselves with these symptoms. They can learn to lessen the intensity and duration of these symptoms. Often these symptoms are the response to a trigger (Copeland, 1998) and when the trigger is recognized, one can create different ways to address their own trigger. In addition, it is important to remember that a feeling of fear may not be an anxiety attack. People feel things. Sometimes, when we are given a diagnostic label, everything that we think or feel is seen through the "lens" of our diagnosis. When we work with people, we want to be ***very careful not to make people's feelings and emotions into symptoms!***



If we continue on with our list of Anxiety Disorders the list looks like this:

Agoraphobia

- Not just a fear of going outside, the person who encounters these symptoms may experience fear in many different situations, many people have a fear of being in a car, on a bridge, or being in crowds…are these people all mentally ill? Remember, these symptoms must significantly impair a person's ability to do the things they want to do.

Phobia

- In general a phobia is a fear of something in particular (snakes, dogs, the dark, high places).

Obsessive-Compulsive Disorder

- The person is overwhelmed by thoughts about a particular thing or many things and it is to a degree that it causes them to have extreme difficulty in life because of these thoughts.
- The person engages in repetitive behaviors or must follow rules in a rigid manner.
- The thoughts are aimed at helping the person reduce feelings of distress; however, that does not often occur.

Posttraumatic Stress Disorder

- The person experienced, witnessed or was confronted with an event or events that involved death, threatened death, or the physical integrity of themselves or others
- The event is re-experienced by the person in dreams, thoughts, behaviors, triggering events or smells, sights, sounds or touches
- The person may try to avoid any kind of triggers associated with the event(s)
- The person may demonstrate responses that impair their daily life and which were not present before the event:
- Difficulty falling or staying asleep
- Irritability or angry outbursts
- Difficulty concentrating
- Hyper vigilance (the person is very aware of who and what is around them all the time)
- Exaggerated startle response

Often, people who experience trauma and abuse, including physical and sexual abuse, experience PTSD. Shery Mead states, **"**Why am I diagnosed with Post Traumatic Stress Disorder, when my abuser clearly had the disorder? Why is he not given a label, but I am?" (January, 2001)

This quote serves to remind us that our reactions to traumatic events in our lives are often what have kept us safe or even alive. As we grow or our lives change, behaviors associated with the traumatic event no longer serve us as they once did. This can cause us to behave in ways that others recognize as symptoms. Moving on and accepting the behaviors we used to get us through difficult events can be part of our healing process. However, each of us will recognize and begin

to change at our own pace. Identifying triggers (Copeland, 1998) is a big step in recognizing behaviors that result from our trauma experiences.

You can conquer your triggers!

Do you have a history of trauma and/or abuse? Have you begun to identify triggers? What are some of the wellness tools that you use to respond to triggers and help you through the behaviors and feelings that occur in response to the triggers?

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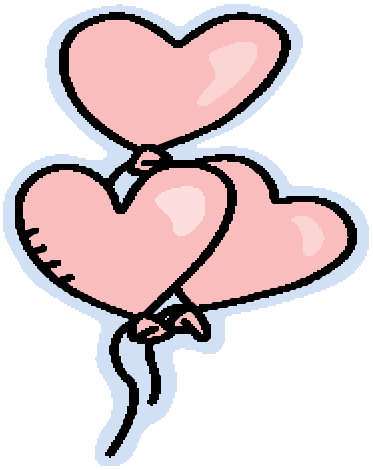


Personality Disorders

Personality Disorders are one of the most stigmatized diagnostic labels that exist in the DSM-IV-TR. They are a diagnostic category that carries hopelessness about recovery. However, many people with personality disorders are living complete and fulfilling lives. Personality Disorders are defined as an:

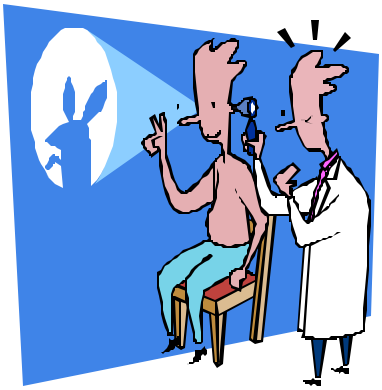
- Enduring pattern of inner experience and behavior that deviates markedly from the expectation of the individual's culture (DSM IV-TR, 2000).

While there are many other characteristics listed within the context of Personality Disorders, the above description gives insight into an aspect of the diagnosis of a personality disorder. Basically, the person does not "fit in" to their cultural group. This leaves one quite concerned about the possibility that immigrants and even emigrants within their own country could be at high risk for a diagnosis of personality disorder. This could be simply because they do not understand or believe in, or follow the norms of a given culture. Of course, there are other aspects that lead to a diagnosis of a personality disorder, but this is a diagnostic label that will require the Peer Support Provider to be especially aware of giving words and feelings to the behavior that is in question.

It should also be noted that with Borderline Personality Disorder, there is frequently a history of abuse. The person has learned to cope in ways that now cause them difficulty. It is possible that a person who has been given a Borderline Personality Disorder may actually have PTSD (DSM-IV-TR, 2000).

These are the main groupings that appear as Serious Mental Illness. However, it is not a complete list. It does not provide any substance regarding the many diagnostic labels that exist. However, it is meant to give you some terminology and diagnoses so that you can understand the words that are being used by people with whom you work.

- **Remember, most psychology students, physicians who are doing a psychiatric rotation, and most people who read the DSM-IV-TR can find a diagnosis for themselves in the manual……Hmmmm. . .**



Everybody has feelings, behaviors, thoughts and events in their life that can make them feel overwhelmed, distressed. These feelings may or may not have anything to do with a mental illness.

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